

Pediatrics & Parents

The newsletter for people who care for children

Richard J. Sagall, MD, Editor

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Approved Sunscreens

Just in time for summer fun, the American Academy of Dermatology has started a program to give it official imprimatur to sunscreen products. The approved products will have the AAD logo with the words "Seal of Recognition" underneath. Approved products will also have a statement from the AAD: "The American Academy of Dermatology recognizes this product for its sun-protection benefit."

For a product to earn the seal, the manufacturer has to provide evidence of water and sweat resistance, phototoxicity stability, broad-spectrum protection (UVA/UVB), and a sun protection factor (SPF) of 15 or higher. In addition, for each product the manufacturer has pay a \$10,000 application fee and an annual registration fee of \$10,000.

The program was started after a survey of AAD members found that 86% thought a seal would help consumers make better choices when selecting sunscreens.

According to Stephen Stone, AAD President, the program "will help consumers make educated choices when purchasing sunscreen products and help maintain the public perception of dermatologists as leading experts in skin cancer prevention."

Family Practice News, 3/1/07

Infection May Cause CP

The cause of cerebral palsy (CP) is not known in 90% of cases, but doctors at Yale-New Haven Hospital believe that prenatal exposure to intrauterine infection may be the cause of many cases of CP. "Recent data suggest that it is the fetus's inflammatory response which causes problems both in terms of preterm labor and neuronal injury," said Errol Norwitz, MD, the program's director. He went to say that even without obvious signs of intrauterine infection, there are subtle changes that indicate infection may be present.

The exact mechanism that causes the neuronal damage (and the CP) is not known. However, the doctors speculate that certain cells that fight infection in the uterus cross into the fetus's brain and cause the damage to the nerves.

Pediatrics News, 3/07

One in ten babies is born with – or develops – skin blemishes. Here are the essential facts on the six most common kinds and the newest ways to treat them.

Hemangioma

What it is: A collection of abnormal blood vessels near or just below the skin's surface, sometimes referred to as a strawberry mark. Though typically not present at birth, it appears within the first few months of life as a cluster of flat, red spots roughly the size of a pimple. The spots proliferate, becoming spongy, blistering masses of any shape or size. (Spots that are flat and appear reddish in color are often called superficial, and ones that are beneath the skin and appear bluish in color are called deep. When the birthmark is both deep and superficial, it is referred to as a compound hemangioma.) After about a year and a half, hemangiomas start to shrink, and they are usually no longer visible by the time a child is between ages three and ten. They are five times more common in females than males. Eighty percent show up on the head or neck.

When to worry: A hemangioma that's on or near your child's nose, mouth, or chin should be treated promptly. "Birthmarks in these areas tend not to fade as readily," says Frank Vicari, MD, a pediatric craniofacial surgeon at Children's Memorial Hospital, in Chicago. Or if they do disappear, they can leave behind damaged tissue, possibly causing a misshapen nose or lip that may require plastic surgery. A hemangioma around a baby's eye is also potentially threatening because it can impair vision. Furthermore, if a child has six or more hemangiomas, he should be evaluated by a specialist. "The more a child has, the higher the risk that some may involve internal organs," says Marcelo Hochman, MD, a facial plastic surgeon in Charleston, South Carolina. In rare cases, a hemangioma can cause internal lesions by growing into organs or leaving scar tissue, most commonly in the liver and spleen. This interferes with organ function and can be life threatening.

Even when a hemangioma doesn't pose a medical risk and is likely to fade over time, experts advise removal if it's noticeable and disfiguring. "By age three, children start to develop a sense of themselves that can be affected by the way other people react to them," says Dr. Hochman. "Having a very visible birthmark can take a psychological toll on a child."

Treatment: Hemangiomas that don't affect the underlying tissue are treated with high doses of oral or

injected steroids, administered over a period of several months. Superficial hemangiomas can also be faded with repeat courses of pulsed-dye laser therapy, a treatment that uses heat to selectively destroy the abnormal blood vessels. Surgery may be needed for hemangiomas that involve deep tissue and for those that affect the nose, eyes, or mouth.

Port-Wine Stain

What it is: A collection of abnormal small veins near the skin's surface that appears flat and reddish at first. Over time, the veins become more engorged with blood and the "stain" may become cobble-looking and deeper red or purple. It can be any shape or size. Unlike hemangiomas, port-wine stains don't go away on their own. "Usually they get thicker and darker over the lifetime of the child," says Hochman. Port wine stains affect fewer than 1% of all births.

When to worry: A port-wine stain that involves at least one upper eyelid and the forehead may signal Sturge-Weber Syndrome (SWS), a rare congenital disorder. With SWS, the extra capillaries near the skin's surface also grow internally and ultimately affect the lining of the brain. Children with SWS are at high risk for glaucoma, seizures, and delayed development.

Treatment: "Most children need six to eight pulsed-dye laser treatments to lighten or remove the superficial component of a port-wine stain," Dr. Vicari says. Treatment can be started as early as one month of age. Results can vary – ranging from no apparent change to complete disappearance of the stain.

Mongolian Spot

What it is: Melanin (brown skin pigment) trapped in the midlayer of the skin. The patches appear as a bluish or grayish bruise on the lower back or buttocks. They are common among African-Americans, Native Americans, Asians, and Latinos.

When to worry: "Mongolian spots are completely benign and present no medical threat whatsoever," says David Green, MD, spokesperson for the American Academy of Dermatology, in Bethesda, Maryland.

Treatment: Time. Most fade completely by age five.

Congenital Pigmented Nevi

What it is: Groups of cells that produce pigment near the surface and in deeper layers of the skin. Congeni-

tal pigmented nevi can be as small as a pinhead-size mole or as large as a baby's entire midsection. These birthmarks are usually raised, dark, and sometimes hairy. Congenital pigmented nevi typically appear at birth or up to several months later. They affect about one percent of newborns.

When to worry: Children with pigmented nevi have a 5-10% greater risk of malignant melanoma. The bigger the marks are, the greater the risk. Massive pigmented nevi can also be psychologically damaging. "Sometimes they're so big that they're hard to hide," says Robin Ashinoff, MD, chief of dermatology and laser surgery at New York University Medical Center, in New York City. "For some kids, getting undressed in a locker room can be quite distressing."

Treatment: Small pigmented nevi can simply be cut out in the doctor's office. Larger ones can be surgically removed through multiple operations.

Cafe-au-lait Spot

What it is: A beige or brown flat, oval patch caused by increased pigment in the skin's surface layer, sometimes called hyperpigmentation. The spots are typically the color of coffee with milk in children with light complexions, and they are usually the color of black coffee in children with darker skin. Up to 20% of the population has a cafe-au-lait spot. It can be present at birth or appear within a week or so afterwards.

When to worry: Six or more spots that are larger than a half inch should be evaluated. "That could be a sign of von Recklinghausen's Disease," Dr. Ashinoff says. This neurological genetic disorder is characterized by soft, fleshy skin growths of abnormal nerve tissue that can put pressure on nerves, impairing normal functioning.

Treatment: For facial cafe-au-lait spots, laser therapy is an option. Results vary. "Some may be removed permanently. Some may darken. Some may only be removed temporarily," Dr. Ashinoff says. Cafe-au-lait spots elsewhere on the body usually aren't treated.

Stork Bite/Angel's Kiss

What it is: A type of hemangioma that involves few blood vessels near the skin's surface. When the patch is flat, pink and on the nape of the neck, it's called a stork bite. A patch on the forehead is known as an angel's kiss.

When to worry: These birthmarks are harmless and often barely noticeable. An angel's kiss usually fades by the time a child is two; a stork bite may never

completely disappear, but it's usually light or hidden by hair.

Treatment: An angel's kiss that doesn't fade may be lightened with laser therapy.

Who Can Help

For a resource list of hemangioma and port-wine stain specialists in your area, log onto The Vascular Birthmarks Foundation at www.birthmark.org. For the names of area pediatric dermatologists, visit the American Academy of Dermatology at www.aad.org.

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Sleep Loss = Weight Gain

Getting less sleep increases the chances children will become obese. Children need a minimum of 10 hours of sleep each night. Yet many children do not sleep enough. And their lack of sleep, especially among younger children, could contribute to the nation's overweight problem.

In a study of nearly 2,300 children three to twelve years old, Emily K. Snell and her colleagues at Northwestern University found "a large decline in weekday sleep across middle childhood and adolescence, driven largely by later weekday bedtimes." By analyzing data – including children's body mass indexes (BMIs), ages, and amount of sleep per night as recorded in time diaries – taken five years apart (1997 then 2002), the team found the less sleep a child got, the greater the risk of becoming obese. Specifically, the researchers found that sleeping less than eight hours a night correlated with a higher BMI both at time one (1997) and five years later. And, they found that sleeping more than 11 hours a night correlated with lower BMIs. Other studies have already shown that children who don't get enough sleep have decreased cognitive and social functioning.

The researchers concluded, "...encouraging parents to put their younger children to bed earlier at night and allowing both younger and older children to sleep longer in the morning, as well as urging school districts to avoid very early school start times for later elementary and middle school-aged children, might represent an important and relatively low-cost strategy to reduce childhood weight problems."

Family Practice News, 3/1/07

Selective Mutism

By Lynda Zielinski

As much as it hurts to have a child burst out in an angry tirade, there's another behavior that can be even more painful for a parent – the silent treatment.

When carried to extreme, mental health professionals have a name for it: Selective Mutism. The child with this disorder is capable of speech but doesn't speak. The child is not developmentally delayed, autistic, or hearing impaired. He does not have a physical problem that prevents him from speaking; he just doesn't talk. That's not to say it's a clear conscious choice, it isn't. Like other psychological problems, it has precursors and underlying symptoms. Selective mutism is more than meets the eye – or the ear, in this case.

Definition

Selective Mutism is a childhood disorder characterized as a failure to speak in some situations despite speaking in others. The disorder has to continue for over a month and interfere with normal social interactions to fit the diagnosis. The term "selective" indicates the child talks in some environments but not others, perhaps at home, but not in school, or on the playground, but not in the classroom. The point is that adults know the child can talk; they've heard him, but they don't know why he won't talk.

Selective Mutism is thought to be rare. The syndrome occurs in only 1% of clients who are seen by mental health professionals, according to the Diagnostic and Statistical Manual of Mental Disorders, IV. However, parents may not seek treatment; they may not think it a serious problem.

Mutism At School

The syndrome may start in children as young as five but sometimes is not noticed until the child is in school and his teachers alert the parents.

Not speaking at school can be triggered by a variety of reasons – fear of ridicule is one. A sensitive child may be afraid of saying the wrong thing and getting laughed at. This is more likely to occur in an only child who hasn't had much exposure to other children. An anxious child may feel inhibited and insecure at school. Also, a child with a speech impediment, such as a lisp or a stammer, is more vulnerable to this form of anxiety. If a child does not speak because he is not comfortable with the English language, he usually only needs more time and exposure to the language. However, if in the interim, the child mispronounces words and becomes embarrassed and self-conscious, it may lead to a problem.

Selective Mutism that occurs at school can be alleviated with cooperation on everyone's part. The teacher needs to instill a helpful attitude on the part of classmates but not go over-board and make the child an oddity. Parents should be patient and reassure the child that he will eventually feel more at ease. If his anxiety is severe, the parent may want to talk to the child's doctor about medication.

It's important to remember that drawing attention to a child's speech is not helpful. Correcting a child or repeating words she mispronounces could make her more self-conscious. The purpose of speech is to communicate. When the child's manner of speaking is more important than the meaning, the child becomes frustrated and speech may become inhibited.

Mutism at Home

Communicating is a need we all have. Children normally want to engage adults, sometimes they chatter to the point of annoyance. But what happens when a child refuses to speak to a parent? This behavior can have ominous consequences. Perhaps the child feels he has been rejected or wronged and uses silence as his weapon. Feeling hurt and angry, he takes his upset out on a parent, most often the mother, although she may not even be the source of his problem. He wants someone to feel his pain.

Nothing is more hurtful than having someone you love refuse to speak to you. The mother naturally responds with hurt and anger. She becomes emotionally out of control, alternately yelling and pleading with the child to get a response. Permitting the child to have so much emotional power over an adult is unhealthy – for everyone. It upsets the rest of the family to witness this emotional tug of war. Everyone becomes exasperated, feeling angry and helpless.

Getting Help

The parent and the child who suffer from this syndrome need professional help to break the cycle. If the mutism is severe and entrenched, as is the case for abused and neglected children, the therapist may need to see the child alone in order to gain his trust. In most cases the parent and child will come in together, or the entire family will be seen. It is not the therapist's job to get the youngster to talk. The therapist will get to know the family. She will find out what's been going on. Sometimes the therapy starts with the parent denying any problems ("We're all fine. he just won't talk.").

In most cases problems gradually emerge. The child has been left home alone, or spends most evenings in the care of a sitter who is less than nurturing. A family member has a substance abuse problem and frightens the child. The child gets blamed for things committed by an older sibling, or gets mistreated by a sibling. The mother has been stressed and has taken it out on the child. She hoped he would forget about it.

Once the floodgates have opened, the dynamic of the parent-child relationship changes. The problems can be addressed. The child feels nurtured and protected. The parent can once again connect with the child.

Unfortunately, not all cases of selective mutism receive help. Sometimes in the records of delinquents and teens with mental health problems are written accounts of the child refusing to talk at some earlier time.

Parents who are overwhelmed with their own problems, who are stressed by work commitments, and who have other children to worry about, may minimize the

problem. Sometimes they look the other way, thinking, "He'll grow out of it, or, one of these days he'll really need me, then he'll snap out of it."

They may be right. The mutism may be a phase. But sometimes different problems follow. At worst, the mutism persists and the child grows into a silent loner. He continues to hold in his anger and upset and doesn't connect with others. He breaks his silence only when he can no longer contain his rage. That's a scary scenario.

It's important to remember that the child is troubled and not bad. Selective mutism may be rare, but we must recognize it and get help for the child early on.

Lynda Zielinski is a teacher, social worker, writer and grandmother of four. She has worked with children and families for many years and is now busily writing about what she has learned along the way. She has been published in Newsweek, The Cleveland Plain Dealer, and Ms. Magazine.

Child Medication Safety Tips

By Vikki Sloviter

Although over-the-counter (OTC) medicines don't require a prescription, many are just as potent as prescription medications. And with the hundreds of medicines that line drugstore aisles, it's often hard for parents to know what OTC is best for their child.

Here are a few tips to keep in mind when buying a non-prescription – OTC – medicine for your child:

1. If in doubt, ask: that's what pharmacists are for. If you aren't sure what a medicine does, or how it might differ from other medicines, ask the pharmacist.
2. Make sure your child's doctor knows of any and all OTCs that your child takes if and when s/he writes a new prescription.
3. Know how much your child weighs. Medication is best given according to a child's weight, so keep a scale at home.
4. Follow the directions on the label. Make sure you read the entire label and understand how often your child can take the medicine, what the side effects could be, and any other information that could affect your child's experience with the medication.

5. Use the dropper or measuring cup that comes with the medicine, not a household substitute. Do not use measuring spoons or other devices, and do not use droppers or cups from other medication bottles. Use only the dropper or cup that comes with the medicine you are giving your child at that time.
6. If administering more than one OTC to your child at a time, check for duplicate ingredients and usage. You may be doubling the dose if you give two different medications that have the same active ingredient. If in doubt, do not give the medicine(s) to your child and call the pharmacist or doctor.
7. Give babies and children medicines only formulated for them. Do not try to estimate dosages by using medicine not made for them.
8. Most OTCs are for temporary relief of minor symptoms. If your child has had a symptom for a long time, or your child is in physical distress, call the pediatrician or emergency room.
9. Do not give medicines in the dark. Turn on a light so you can properly measure the medicine.

Adapted from www.bemedwise.org.



Children in Hospitals

By John E. Monaco, MD

Mother's Day

I was on call Mother's Day weekend this year. It was unfortunate that our family couldn't spend the day together, but it wasn't as bad as it could have been, however, since my daughter spent the weekend with me at the hospital. For her senior project she had been assigned to "shadow" me and then write her reactions to what I do and the patients we would see. Since she has expressed some interest in medical school someday, I thought the experience might give her a glimpse into one possible career choice.

One of the first patients we saw was a little girl named Kathleen. She was two years old and had been infected by a bacteria I have written about all too frequently here – MRSA, or Methicillin-resistant *Staphylococcus Aureus*. This is a bacterium, once confined to hospitals and nursing homes, is now ubiquitous in the community. It is primarily responsible for skin and soft tissue infections, but it has been known to invade joints and even bone. It is extremely virulent and aggressive and there are only a handful of antibiotics that work against this frightening organism.

Kathleen had been seen in the ER two days earlier with a small skin infection on her shin (she had no primary care pediatrician). It appeared to the ER doc to be MRSA, so he started her on an antibiotic called Bactrim, which has been shown to be fairly effective against this organism. Two days later she returned to the ER because the infection was getting worse. Basically, her leg was a mess. It was swollen and red from hip to toes and was so painful that Kathleen was not able to walk on it. She would not let us examine it because of the pain, but when I did get close enough to touch her leg, I realized it actually felt hot. Redness, swelling, pain and heat are hallmarks of infection, and when ALL are present to this degree of severity, it is truly a worrisome infection.

I showed my daughter how to examine a two year old (a challenge in the best of circumstances) and we both seemed to have established a workable rapport with both Kathleen and her mother. That was, until we began to initiate treatment. When I informed Kathleen's

mom that I did not know how long her daughter would be in the hospital, her affect suddenly changed. What had been a cheerful expression now turned sullen and suspicious. She ceased to make eye contact with us. Since we had completed our history and physical examination, my daughter and I retreated to the call room where we could write admission orders and discuss the case. Suddenly there was a knock at the door. Kathleen's nurse had come to tell us that the mother wished to take Kathleen home where she would resume the antibiotics that had already been prescribed (the ones that didn't work!). It seemed she had a problem with her other child, and she had no one to call to give her some help. The nurse asked if we could go to her room and attempt to talk her into staying.

This scenario is always a bit sticky for me. Essentially this patient was refusing treatment, which every patient theoretically has the right to do. Ordinarily, if patients decide to leave the hospital before their physician feels they are ready, they simply sign a form stating that they are signing out "AMA" (Against Medical Advice) and they are on their way. There are insurance ramifications to signing out AMA, but there is nothing illegal about it... unless this rejection of care involves a child. If parents take a child out of the hospital against the advice of physicians, they are basically denying that child care, which is considered essential, and therefore they are putting the child in potential danger, thus committing a form of child abuse or neglect.

I typically try everything I can to keep this from happening, and usually I'm successful. In the case of Kathleen's mom, however, I couldn't get her to budge. The issues she needed to attend to at home – about which I knew nothing and therefore was in no position to judge – were apparently so overwhelming that this mother simply could not bear the possibility of spending the night or possibly several nights in the hospital away from home.

When I was not able to convince her, we asked the social worker in to discuss the situation with the mom. This conversation led to a child protective services referral and even a visit by the sheriff who told her, "The staff

can't physically stop you from leaving with your baby, but the minute you do, you will be arrested, and your child will be taken away." It helped that he was 6 foot 5 inches tall and over 250 lbs., making him far more persuasive than I could ever have been. Kathleen's mom eventually relented and the risk of Kathleen fleeing quickly abated.

From her point of view, my daughter was horrified that a mother could jeopardize the life of her child for the sake of some other pressure to get home. I told her that the unfortunate reality of pediatrics is that we cannot always count on parents to act solely in the best interest of their children. She sighed, said the situation "sucked" and then said something profound. "It's funny you know," my wiser-than-her-years daughter said. "This horrible mother would try to take her child out of the hospital, risking her [daughter's] life because of something she needed to take care of at home, and she would do all this on Mother's Day." Always a sucker for irony and poignancy, I could only nod in agreement.

Kathleen remained in the hospital one week later. Her leg was somewhat better but only after aggressive antibiotics that required constant adjustment, as well as a trip to the operating room to drain an abscess that developed during her treatment. We're not sure when she'll go home, but it will be only when we are assured that her prognosis is good, and that she will do well on oral antibiotics. My daughter finished her project with a much more realistic view of what I do, and hopefully not too big a dose of disillusionment.

John E. Monaco, M.D., is board certified in both Pediatrics and Pediatric Critical Care. His new book, Moondance to Eternity, is now available. He lives and works in Tampa, Florida. He welcomes your comments, suggestions, and thoughts on his observations.

Fruit Juice and Obesity

In low-income families that receive food through the federal WIC program (Women, Infants and Children), fruit juice consumption among obese or at-risk-for-becoming-obese children contributes to worsening obesity. For non-obese children, however, fruit juice consumption has no impact on their risk of becoming obese. Fruit consumption, on the other hand, was not associated with any increased risk of weight gain in any of the children.

One other interesting finding - parents were significantly more likely to restrict girls' food intake than boys.

Pediatrics, 11/06

Infant Mortality Rates and Our Nation's Health

How healthy is our nation? Recent studies and press reports tell us that we're not doing so well. We have historically high rates of obesity and heart disease, indications that we aren't eating healthily. But another way to assess a nation's health is to look at its infant mortality rate, the annual rate at which infants under one year of age die. The United States' infant mortality rate has declined over the past few decades. In 2006, the rate was 6.4 deaths per 1,000 live births, which is markedly lower than the 1950 rate of 29, and the 1980 rate of 12.6 deaths per 1,000 live births.

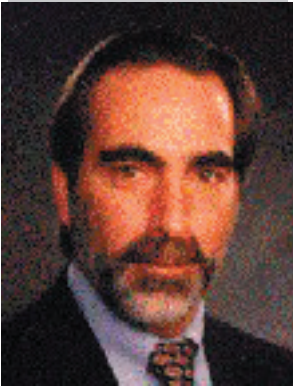
A recent study conducted by the Division of Vital Statistics of the National Center for Health Statistics examined pre-term infant mortality rates in the U.S. from 1999-2004, specifically looking at disparities among racial and ethnic groups. The results indicate that the rate of pre-term infant mortality – infants under one year of age who die as a direct result of being born before 37 weeks gestation – has increased in the past five years, from 34.5% in 1999 to 36.1% in 2004. How is it that the U.S.'s infant death rate has significantly decreased but its pre-term infant death rate has recently increased? The researchers believe that more babies are being born prematurely or at lower birth weights.

Interestingly, in 2004, the rate of pre-term infant mortality for non-hispanic black infants was three times that of non-hispanic white infants. The study did not attempt to explain why the pre-term infant death rate was higher for non-hispanic black infants, but the researchers hope to use the results to better understand the role of pre-term birth in causes of infant mortality. And, they stressed the importance of identifying women at risk of pre-term delivery and finding ways to prevent such an event.

Percent of total infant deaths in 2004 that were pre-term related, by maternal race/ethnicity:

All	36%
Non-Hispanic black	46%
Puerto Rican.....	40%
Central/South American.....	35%
Asian/Pacific Islander	35%
Total Hispanic	33%
Non-Hispanic white	32%
Mexican.....	31%
American Indian/Alaskan Native	22%

"Trends in Preterm-Related Infant Mortality by Race and Ethnicity: United States, 1999-2004" National Center for Health Statistics



Perspectives on Parenting

By Michael K. Meyerhoff, EdD

A Timetable For Talking

Has your baby started talking yet? Perhaps no other question more commonly generates anxiety among the mothers and fathers of infants and toddlers who are still largely silent. While walking and other physical skills tend to permit a relatively relaxed and patient attitude, waiting for the first words seems to cause all sorts of serious and uncomfortable concerns about everything from the little one's inherent intelligence to the capacity of the parents to raise their offspring properly.

So when should parents start to worry that something may be wrong if their child has yet to speak? The answer to that question is a bit complicated, but it should be reassuring in most cases.

First, it is important to understand the distinction between "receptive" and "expressive" language. Receptive language is comprehension or the understanding of words. Expressive language is speech or the saying of words. While parents are inclined to focus on expressive language, it is actually receptive language that provides the clearest indication of a young child's progress during the first three or four years of life.

Second, it is important to understand the distinction between "average age" and "normal range." Many charts that appear in books and articles about early development indicate the average age at which children achieve various abilities such as walking and talking. But the average age is essentially a meaningless statistic. What parents need to focus on is the normal range, which is the entire period during which a skill can appear and the child is still considered solidly on schedule with regard to normal development.

Now let's start with receptive language. The normal range for the onset of the understanding of words is very early and very narrow – six to eight months. By eight months of age, a child should show signs of understanding a few simple words and phrases, such as "bottle," "wave bye-bye," "give me a kiss," etc. And from that point on, receptive language should proceed steadily and quite rapidly. By a year of age, the child's receptive vocabulary should expand to a couple of dozen words and phrases; by two years of age, it should

include two or three hundred words or phrases; and by three years of age, the child should understand approximately two-thirds of all the everyday language he will use for the rest of his life.

Expressive language is an entirely different story. The normal range for the onset of the speaking of words is huge – six months to two years of age. Some children who are developing beautifully and who eventually will have superb language skills start talking during the second half of the first year. Other children who are developing beautifully and who eventually will have superb language skills don't say much of anything until the second birthday.

In addition, once expressive language development starts, it does not always proceed at a rapid and regular pace. Many children will spend several months using just a single word to express themselves (what professionals refer to as a "holophrase"); they may spend many more months using two or three word phrases (what professionals refer to as "telegraphic speech"); and they may not begin to employ full sentences until sometime after their third birthday. Again, despite the fact that they may have considerably more eloquent peers, these children are still well within the normal range.

What is critical for parents to realize is that differences within the normal range have absolutely no significance. So as long as receptive language is on track, a child who starts talking at eight months is not "advanced" or "ahead," and a child who is not talking at 18 months is not "slow" or "behind." While it may be a difficult concept for parents to digest, the fact of the matter is that from a developmental standpoint, the two children are identical.

Unfortunately, we live in a highly competitive society, and most parents have not been enlightened about normal ranges. Consequently, one set of parents may say to another, "Your Johnny is 18 months old and hasn't started talking yet? Our Janie has been talking since she was eight months old!" And their implication clearly is, "Our Janie is a genius, and your Johnny is retarded." Obviously, this is as inaccurate as it is inappropriate, but it is hard not to take it to heart.

Nevertheless, parents must strive to be patient and concentrate on what is truly meaningful. Wallowing in needless anxiety and engaging in improper comparisons will not do anyone any good. The following are some suggestions for dealing with your child's language development in a productive manner.

Monitor Receptive Language Development

After your child passes the six-month mark, look for indications that he is starting to understand some simple words and phrases; and then make sure that he continues to show progress in this area. If he is nine or ten months old and shows no signs of comprehension and/or if he appears to be stuck at any point, it would be wise to take him to the pediatrician. It may be that he is suffering from a mild to moderate hearing loss or some other problem that can be and should be quickly and easily corrected.

Don't Waste Money on Useless or Unnecessary Products and Services

Regrettably, there are a lot of greedy publishers who have no qualms about cashing in on parental anxiety. As a result, you will find a number of books with titles such as *Teach Your Baby to Talk*. The truth is that no one has ever figured out how to get a child to start speaking before he is ready. Following the procedures outlined in these manuals will not hasten the onset of your child's expressive language and thus will only contribute to your anxiety when they don't work.

Even more regrettably, there are some irresponsible professionals who are quick to diagnose a problem when one does not really exist. I recently read a textbook for special educators in which a condition called "Early Expressive Language Delay" was defined as "a lag in expressive language development evident by age two." That same textbook cited some statistics showing a significant number of "language disorders" during the preschool years, and then a drastic drop during the elementary school years. I think it is clear that most of those "disorders" were caused by over-diagnosis and cured by the normal course of development.

Talk to Your Child Even if He Doesn't Talk Back

The one factor that does seem to have a major impact on early language development is the amount of language to which a child is exposed from birth. Unfortunately, it is not natural to speak to someone who remains silent. Consequently, it may take a concerted effort to keep up a substantial conversation during those initial months when the conversation will be strictly one-sided. And by the way, it turns out that only "live language" makes a difference. Sitting the child in front of the television

set when *Sesame Street* is on or exposing him to "Baby Einstein" videos and other such products will not have any long-term benefits at all.

Strive to Avoid the Second Child Syndrome

While there are plenty of exceptions, first-born children as a rule do better in early language development than later-born children. For one thing, parents can give their full attention to the first born, and they simply do not have the time and energy to devote that much attention to their later borns. For another thing, the first born receives attention almost exclusively from them – and they are providing good language models and constantly encouraging progress. Later borns are often left in the hands of older siblings who are not yet speaking particularly well and who are content to continue responding to grunts and gestures. So when dealing with a second or third child, you need to be a little more conscientious and a bit more patient.

Relax But Remain Alert

If your child is less than two years of age, again, as long as he shows steady progress in receptive language, you should not fret if he does not speak – despite the critical comments you are likely to receive from neighbors, friends, and relatives (particularly your mother-in-law). However, if your child has passed the second birthday and either shows no interest in expressing himself verbally or seems to be frustrated by continually unsuccessful attempts to do so, then it would be wise to consult a professional. Going beyond the normal range does not automatically mean there is a significant problem, but this is the point when a modicum of parental concern becomes legitimate and when at least some precautionary action becomes appropriate.

Michael K. Meyerhoff, Ed.D., is executive director of The Epicenter Inc., "The Education for Parenthood Information Center," a family advisory and advocacy agency located in Lindenhurst, Illinois. He may be contacted via e-mail at epicentrinc@aol.com.

PediaTrick

Eye Drops Tip

Putting eye drops into your child's eyes can be a trying experience for parents and child alike. Refrigerating the eye drops helps in two ways:

- Cool or cold eye drops tend to sting less than those at room temperature.
- It's easier for your child to tell you if the drops made it into her eye.

Consultant, 3/07

In the Heat of the Night: How to Handle Febrile Seizures

By M.D. Torres

It's the middle of the night. You check on your toddler before turning in. You notice his cheeks are flushed and he feels warm. You take his temperature and it's a staggering 104°F. You give him Tylenol and begin to wipe him down with a cool cloth in an effort to get the fever down. Suddenly, he begins to tremble. His eyes glaze over and become fixated. He's not responding to your voice. You frantically dial 9-1-1 because you think your child is dying. As sirens begin to wail in the distance, your child stops trembling and recognizes your face. He's responsive and acting "normal" again. When the EMTs arrive, you explain the terrifying ordeal you've witnessed. They tell you your child has just experienced a febrile seizure.

What are Febrile Seizures?

Febrile seizures are convulsions brought on by a sharp, sudden increase or decrease in body temperature generally stemming from an infection in the body. There are two types of febrile seizures: simple and complex. Simple febrile seizures are more prevalent and last in duration from a few seconds up to ten minutes. Simple febrile seizures usually do not require medical intervention.

Complex febrile seizures are more serious. They last for more than fifteen minutes, recur within twenty-four hours, and sometimes only affect one side of the body. Medical intervention is necessary and it is recommended that you call 9-1-1.

What are the Symptoms of Febrile Seizures?

- A fever greater than 102 degrees
- Shaking or jerking of the limbs on one or both sides of the body
- Loss of consciousness
- Eyes rolled back into head or fixated gaze
- Breathing difficulty
- Moaning or wailing in varying degrees of severity

What Do I Do While My Child is Having a Seizure?

It can be very traumatic to watch your child in a seizing state, but you must remain calm in order to take measures to safeguard your child from inflicting self injury. Here are some of the things you can do if your

child is experiencing a seizure:

- If he is standing, help him to the floor so that he doesn't fall and injure himself.
- Do not put anything in his mouth. No food, drink, or meds at all while he is seizing.
- Turn him on his side so that he doesn't choke on an accumulation of saliva.
- Don't restrain his movements.
- Time the seizure as best you can by watching a clock or a watch.
- Call for emergency personnel if the seizure lasts longer than ten minutes.

Are febrile seizures harmful?

Usually, simple febrile seizures are not cause for concern. While they are not likely to cause neurological damage or other lasting effects, it's still a good idea to have your child examined after he has the initial febrile seizure, if for nothing else, to diagnose and treat the underlying cause of the fever – infection. In cases of a complex febrile seizure where the seizure lasts for more than fifteen minutes or is accompanied by vomiting, difficulty breathing, sleepiness or lethargy, have your child seen in the emergency room.

Which Children are Prone to Recurring Febrile Seizures?

The younger the child is when he has his first febrile seizure, the more likely he is to have recurring ones. (It's rare that initial febrile seizures occur before six months of age or after the third year.) If the initial seizure occurred very early in the onset of the fever or if the fever was only low grade, the probability of subsequent febrile seizures is also more likely. Having immediate family members who suffer from febrile seizures also has much bearing on your child's likelihood of developing recurring febrile seizures.

Febrile seizures affect fewer than 5% of children between the ages of six months and five years. This equates to roughly one in twenty children. Of this group, 33% will go on to have recurring febrile seizures before they're out of the six-month - five- year age window.

Does Epilepsy Cause Febrile Seizures?

Febrile seizures are not caused by epilepsy. Epilepsy is two or more seizures without the presence of fever.

Although some epileptic children do have their first seizure during a fever, only about 2% of children who experience febrile seizures go on to develop epilepsy.

There are children who are more prone to developing epilepsy than others. They are: children who have complex febrile seizures, children with cerebral palsy, and children with other developmental delays. Without these risk factors, approximately two in 100 will go on to develop epilepsy.

What Methods are Used to Diagnose and Treat Febrile Seizures?

If the physician has cause to believe the fever was brought on by something more serious than a common childhood ailment (ear infection, cold, etc.), he may do a spinal tap to rule out meningitis and encephalitis, both potentially deadly infections of the brain and central nervous system components.

If your child experienced diarrhea or vomiting beforehand, the seizure could have been a result of dehydration. Otherwise, routine blood work and a possible urine or stool sample would be in order to determine where the infection is based. Hospitalization typically isn't necessary. If the seizure was lengthy or accompanied by a bad infection, or if the source of the infection could not be determined, the doctor may suggest admitting the child for a couple of days for observation.

Can Febrile Seizures be Prevented?

If a child is prone to febrile seizures, the parent may opt to medicate the fever with Tylenol or Motrin at the earliest indication of onset. However, there have been no studies to show that this treatment has any effect on warding off febrile seizures.

Daily use of anticonvulsant drugs isn't generally recommended due to the risk of side effects involved. For children who are very prone to recurring febrile seizures, the doctor may prescribe diazepam to be given either rectally or orally, when fever is present. While this drug usually doesn't cause side effects, drowsiness, loss of balance or overactivity can sometimes result.

Research is still being done on febrile seizures and more information is becoming available everyday. The Internet can provide a wealth of information for parents who are interested in investigating febrile seizures in more detail. Your child's pediatrician is also a good source to turn to since s/he knows your child's medical history.

M.D. Torres is a freelance writer living in Texas. A former preschool teacher and mother of three, M.D. Torres has penned several articles on varying early childhood topics. She can be contacted via e-mail at m.d.torres@sbcglobal.net

Breath-Holding Spells in Toddlers

By Angela M. Simpson, MD

Your toddler is happily playing when suddenly she becomes frustrated and upset. She lets out a brief, loud cry with a forceful expiration... and then silence. She looks as though she's crying because her face is strained, but no sound comes out. She doesn't take another breath. She begins to turn blue. You watch, terrified, but she still won't breathe in. You feel your own heart start to pound as her body becomes limp. Then she becomes unconscious. Her arms and legs begin to jerk...

Breath-holding spells are one of the most frightening and unnerving behaviors that a parent may witness. Despite their dramatic appearance, they are benign and harmless to the child. These episodes always occur in response to an emotional trigger, such as anger, agitation, pain, or frustration. The child will begin to cry, but then stops mid-cry in a "noiseless expiration." This is followed by a dramatic facial color change from

red to blue. The episode ends spontaneously, without any intervention, when the child takes a sudden, deep inspiration. In more severe cases, the child may become limp or pass out. Real seizure activity may occur as part of the spell, but this is not harmful, and there is no increased risk of subsequent seizure disorder. Breath-holding episodes may last several seconds to more than a minute.

There is another, far less common, type of breath-holding episode called a pallid spell. During this type, the child will turn very pale. These are brought on by a sudden startle, such as a minor bump on the head. The child will stop breathing, go limp, become unconscious, and become dramatically pale. This type of breath-holding episode also resolves spontaneously.

Breath-holding spells are fairly common. Simple spells, in which there is no associated loss of consciousness,

occur in up to 25% of healthy kids. Severe episodes, which include limpness, loss of consciousness, and/or seizure activity, occur in about 5% of children. Up to 20% of children with breath-holding episodes have family members who were similarly affected during childhood. Breath-holding spells typically begin in the age range of six to eighteen months. These episodes may occur as often as several times a day, or as rarely as once a year. They occur with greatest frequency in the second year of life. Once parents have witnessed one breath-holding spell, often they can predict when another is about to happen. Children outgrow this behavior, usually between the ages of four to six years.

After a first breath-holding spell occurs, a pediatrician should evaluate your child. Breath-holding spells share some features in common with other more serious disorders, such as seizures, cardiac problems, and rhythm disturbances. A detailed description of the circumstances and sequence of events at the time of the episode may be all that the doctor needs to confirm the diagnosis of breath-holding. For instance, breath-holding spells are always triggered by an emotion, such as frustration or pain. In contrast, generalized seizures and cardiac disturbances usually do not have a precipitating emotional event. In breath-holding spells, children will turn blue before they pass out and before seizure activity occurs. The sequence of events is different in a child with an epileptic seizure disorder, where the child may turn blue during or after the seizure, but not before. In addition to a detailed history, your pediatrician will perform a physical exam of your child, with close attention to the cardiovascular and neurological systems.

If your child's doctor confirms that the episode was indeed a breath-holding spell, your child may be checked for anemia. There is an association between iron deficiency anemia and breath-holding spells, and treating the anemia will often decrease the frequency of passing out.

Breath-holding episodes are harmless, in the short run as well as the long run. Children outgrow breath-holding spells without any increased risk of epilepsy or other neurological problems. The only significant finding on follow-up of kids with breath-holding spells is a mildly increased incidence of syncope (passing out) in later childhood and adolescence.

What should you do when your child is holding her breath and turning blue? First, do not panic. Keep in mind the episode will resolve spontaneously, usually within a minute or so. Many parents will try splashing water on their child or blowing in their face, but this is not necessary. You should not start CPR or shake your

child. The best thing to do is to lay your child down on her side. This will prevent injury should your child pass out. As soon as she loses consciousness, she will begin to breathe on her own within seconds. She may be a little sleepy after the episode, but then will resume her usual activity.

How to react to a child's breath-holding spells can be a big challenge for parents. Giving your child extra attention after an episode, showing excessive worry, or bending to your child's will are all tempting and natural responses as a parent, but will only serve to reinforce the breath-holding behavior. Some parents avoid disciplining a child, fearful of the very real possibility that conflict or disappointment will provoke another spell. Try not to fall into this trap. You still need to set limits with your toddler, even if she gets so frustrated that she holds her breath until she passes out.

Angela Simpson, MD, is board certified in both Pediatrics and Internal Medicine. She completed her residency at the University of Rochester, New York, and currently works in a community practice in Fall River, MA.

Obesity May Cause Foot Pain

It's a vicious cycle you'd expect in an older population, not the young: an overweight person wants to exercise to lose weight, but because of foot pain caused by a medical condition brought on by being overweight, she can't exercise.

Unfortunately, doctors with the American College of Foot and Ankle Surgeons are seeing such scenarios not among older, overweight patients, but among pediatric patients, some as young as age four.

Since the foot consists of 26 bones, 33 joints, and more than 100 muscles, tendons and ligaments, and foot bones don't mature until around age 14, obese children are at greater risk for Sever's disease - an inflammation of the heel's growth plate due to muscle strain and repetitive stress. Unfortunately, for these overweight children, walking or exercise increases the pain.

Orthopedists can treat the children's foot pain with orthotics or therapy, but they also advise parents to take a more active role in improving their children's diets and lifestyles, so their children won't be in pain anymore.

Medical News Today, 1/21/07



Dr. Eden Answers Your Questions

Dr Alvin Eden is a pediatrician with over 40 years of experience. He practices in Forest Hills NY, is chairman of the department of pediatrics at Wyckoff Heights Medical Center, Brooklyn, NY and is a clinical professor Pediatrics at Wyle Cornell Medical Center in NY. He is the author of a number of child care books. His latest, *Positive Parentings*, will be published this September.

Send your questions to QandA@pedsforparents.com or to Pediatrics for Parents, 120 Western Avenue, Gloucester, MA 01930. Please keep them general in nature as we can't give specific advice nor suggest treatment for your child. All such questions should be asked of your child's doctor.

Toe Walking and Walkers

Q My nine-month-old son loves to get around in his walker, and when he "walks," he walks on his toes. Is this a problem?

A The toe walking is not a problem. It is rather common and is considered perfectly normal. In due time the toe-walking group of children start to walk on the balls of their feet and off their toes. There is no reason to worry about it and there is nothing to be done to correct it.

However, there is a problem with his using the walker. Despite the fact that he loves it, my best advice is to get rid of the walker. These devices have been shown to actually hinder and slow up the progress of learning to walk. They eliminate the drive to learn to walk since they allow the baby to move around so easily. Further, walkers are also serious safety hazards. They can tip over easily, and babies that scoot around in walkers are more likely to get into dangerous places that would ordinarily be beyond their reach. Many accidents and poisonings are directly related to walkers. The Academy of Pediatrics has officially recommended that walkers not be used, and I agree.

Ear Infections

Q My 10-month-old daughter already has had four middle ear infections. Her doctor has mentioned the possibility of putting little tubes in her ears. What exactly are those tubes and what do they do?

A Your baby's history is not that unusual. Next to the common cold, a middle ear infection (otitis media) is the most frequent reason for a sick visit to the pediatrician. Studies have shown that by age five,

well over half of all children have had a least one case of otitis media.

The fact that your little girl already has had four separate middle ear infections demonstrates that she is in the group of children prone to this problem, so there is a good chance that she will continue to suffer further episodes. However, as she gets older there usually will be fewer infections.

One of the ways to treat recurrent middle ear infections is to insert little ventilation tubes (tympanostomy tubes) into the eardrum in order to help drain the middle ear cavity. Recent studies have questioned the effectiveness of these tubes and have identified problems they may cause. My best advice is not to rush into using these tubes but rather to properly treat each infection under the direction of your daughter's doctor. It may be necessary to use the tubes, especially if there is a significant hearing loss for a long period of time.

The key is early diagnosis and, when indicated, the correct antibiotic as prescribed by your daughter's pediatrician. Decongestants have been shown not to work.

Some final advice: after treatment of a middle ear infection, it is normal and expected for the fluid to remain in the middle ear cavity for weeks or even months, which does not usually require any treatment. The body gradually absorbs the fluid, but it may take several months to do so.

What You'll Find on the Website...

- Safety News and Recalls
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www.pedsforparents.com

Eating in Groups

According to a recent University of Michigan study, when young children are in groups, they eat more than when they eat alone or with a couple of other kids. Dr. Julie Lumeng and her colleague evaluated the data from 54 preschool-aged children who participated in the study to see what, if any, the effect of group size had on food consumption.

The children that ate in groups of nine ate 30% more than children that ate in groups of three. All the groups were given the same amount of food (graham crackers). The children in the larger groups also ate faster and socialized less than the children in the smaller groups.

What is significant about these findings? Even though the sample size was small (54 children), Lumeng believes that "... given that the social facilitation effect can overwhelm satiety mechanisms, its potential role in contributing to overconsumption, and thereby increasing overweight risk in children, deserves consideration in future research." She also concluded that parents could use such information to help their under-eater eat more (by eating in a larger, family setting, for example), or their over-eater eat less (by eating in a less chaotic environment such as a fast food restaurant).

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